STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535034	A. BUILDING _____ B. WING _____	03/27/2025

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/24/25 through 3/27//25. The following common abbreviations are used throughout this document: DON: Director of Nursing CNA: Certified Nursing Assistant MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		4/18/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/18/2025

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F 758	Continued From page 1 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a gradual dose reduction was performed for 1 of 5 sample residents (#28) reviewed for unnecessary medications. The findings were: 1. Review of the quarterly MDS assessment dated 1/6/25 showed resident #28 had a brief interview for mental status score of 14 out 15, which indicated s/he was cognitively intact, and diagnoses which included end-stage renal	F 758	Survey Date: 3/27/25 F-Tag: F758 – Unnecessary Medications Completion Date: 4/18/25 _____ PLAN OF CORRECTION Corrective Action Taken for Resident Found to Have Been Affected by the Deficient Practice: Resident #28's medication regimen was reviewed by the interdisciplinary team	

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F 758	Continued From page 2 disease and insomnia. Further review showed the resident used antidepressant medications during the look-back period. Review of the resident's physician orders showed s/he received trazodone (antidepressant) 50 mg by mouth at bedtime related to insomnia which was ordered on 7/21/23. The following concerns were identified: a. Review of the treatment administration records for January, February, and March 2025 showed the facility was monitoring the resident for restlessness at night and there were no documented episodes of restlessness indicated. b. Review of a "Consultation Report" dated "January 1, 2025 through January 18, 2025" showed the pharmacist recommended to "...Please attempt a gradual dose reduction (GDR) to 25 mg qhs (every day at hours of sleep). If you do not wish to decrease, please document risk vs. benefit of continuing Trazadone..." The review showed the physician declined the recommendation because a GDR was "Clinically Contraindicated" for the resident and checked the box for "the resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below." Further review showed there was no additional or resident specific information documented below. c. Review of a "Consultation Report" dated "May 20, 2024 through May 22, 2024" showed the pharmacist recommended "If clinically appropriate, please consider a gradual dose reduction (GDR) to trazadone 25 mg daily, while concurrently monitoring for reemergence of target and withdrawal symptoms." The review showed the physician declined and checked the box that	F 758	upon identification of the deficiency. On 4/16/25, the attending physician decreased medication following staff interview and review of the sleep study. The Trazodone order on resident #28 was decreased to 25 mg on 4/16/25. She will be monitored to assess if she has adverse effects, if no adverse effects are noted then further decrease(s) to occur. _____ How Other Residents Having the Potential to be Affected Were Identified and What Corrective Action Was Taken: A facility-wide audit was initiated on 4/14/25 to identify any other residents receiving psychotropic medications (antidepressants, antipsychotics, anxiolytics, sedatives/hypnotics) without evidence of appropriate GDR evaluation or documentation. The audit is being conducted by the Director of Nursing (DON) and Assistant Director of Nursing and is scheduled for completion by 4/18/25. Any additional residents found with incomplete or missing GDR documentation will be reviewed by the physician and IDT. Corrections and updated clinical documentation will be completed for those residents. _____ Measures or Systemic Changes Put in Place to Ensure the Deficient Practice Will Not Recur: 1. Policy/Standard Review and Staff Training: All nursing staff, including licensed nurses	

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F 758	Continued From page 3 stated "Continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating and underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW... " Further review showed the physician wrote "[S/he] is able to sleep with trazadone." d. Review of a "Consultation Report" dated "January 29, 2024 through January 30, 2024" showed the pharmacist recommended "If clinically appropriate, please consider a gradual dose reduction (GDR) to trazadone 25 mg daily, while concurrently monitoring for reemergence of target and withdrawal symptoms." The review showed the physician declined and checked the box that stated "Continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating and underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW... " Further review showed there was no additional or resident specific information documented below. 2. Interview with the DON on 3/27/25 at 10:22 AM revealed the resident #28 previously had a successful gradual dose reduction attempted and she was unable to find any unsuccessful attempts. In addition, she was unable to locate where the physician provided additional resident specific information for the need of the medication. 3. Review of the facility policy titled "Psychoactive Medication and Medication Regimen Review Management Standard" dated "9.2024" showed "...5. Gradual Dose Reduction/Tapering of	F 758	and nurse managers were reeducated on 4/16/25 on our Psychoactive Medication and Medication Regimen Review Management Standard and will have an in-service meeting on 4/23/24 at 2:30 PM regarding: o GDR guidelines in the standard. o Physician responses to pharmacist recommendations. o GDR decisions, including individualized clinical justifications. 2. Provider Expectations: All prescribing clinicians and our Medical Director were re-educated through written correspondence on 4/16/25. They were reminded of regulatory expectations and required documentation elements related to psychoactive medication use and GDR. _____ How the Facility Will Monitor Its Corrective Action to Ensure That the Deficient Practice Is Being Corrected and Will Not Recur: • The ADON or designee will complete monthly audits of all residents prescribed psychoactive medications to ensure: o GDR opportunities are considered. o Appropriate, individualized physician documentation is present when GDR is declined. • Audit findings will be reported to the QAPI Committee monthly for 6 months or until sustained compliance is achieved (defined as 100% compliance for 3 consecutive months). • Any identified deficiencies will result in immediate corrective action and staff/provider re-education.	

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F 758	Continued From page 4 Medications: The requirements underlying this guidance emphasize the importance of seeking an appropriate dose and duration for each medication and minimizing the risk of adverse consequences, The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying cases of the original symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing symptoms..."	F 758		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880		4/18/25

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F 880	Continued From page 5 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 6 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were implemented during meal delivery and assistance during 2 of 3 meal observations in the main dining room. The census was 56. The findings were: 1. Observation on 3/24/25 beginning at 5:43 PM showed CNA #1 was assisting a resident to eat dinner. The CNA was observed touching the resident's shoulder, arm, and wheelchair wheel while assisting the resident. Without performing hand hygiene, the CNA moved around the table and was observed placing her ungloved hand on top of another resident's hamburger and using her other hand to cut the hamburger in half. After it was cut, the CNA picked up half the hamburger, using both hands, and handed it to the resident, which the resident ate. The CNA then used her ungloved hand to pick up a French fry, dip it in ketchup, and hand it to the resident, which s/he ate. The CNA again picked up the resident's hamburger and handed it to the resident before standing from the table at washing her hands at the sink in the dining room. 2. Observation on 3/26/25 beginning at 12:04 PM showed CNA #1 assisted a resident by cutting his/her food and then touched the resident's shirt. The CNA left the table and obtained another plate at the kitchen window and took it to a 2nd resident, where she cut up the food using his/her silverware. The CNA placed her hand into her	F 880	F880 – Infection Prevention & Control Completion Date: 4/18/25 _____ _____ Plan of Correction (POC) 1. Immediate Corrective Action: o CNA #1 was immediately re-educated on hand hygiene and glove use during resident meal assistance on 3/27/25 at 2:30 PM. CNA completed Hand Hygiene Competency with licensed nurse on 4/18/25. 2. Systemic Changes: o All CNAs and dietary staff were re-educated on the facility's hand hygiene and infection control policies with special emphasis on: ¿ When to perform hand hygiene. ¿ Proper glove use when handling resident food. ¿ Avoiding cross-contamination during meal service. o Re-education was completed by the Infection Preventionist and Dietary Manager to team members on 3/27/25 at an All-Staff meeting with a presentation on hand hygiene. On 4/15/25 a hand hygiene class was sent out on our online education platform. On 4/15/25 all team members received a paper handout on proper Hand Hygiene and signed a form to demonstrate understanding of the	

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F 880	Continued From page 7 hair then obtained another plate from the kitchen window and delivered it to a 3rd resident. While delivering the meal tray, the CNA touched the resident's wheelchair before returning to the kitchen window to obtain another tray and delivering it to a 4th resident. No hand hygiene was performed during the observation. 3. Interview with the DON, infection preventionist, and dietary director on 3/27/25 at 9:48 AM revealed hand hygiene should occur during meal service between residents if resident contact occurred. They confirmed the CNA should perform hand hygiene before assisting a second resident and they would like staff to wear gloves if they are touching the resident's food items. Further interview revealed they expected hand hygiene to be performed after touching potentially contaminated items. 4. Review of a facility procedure titled... "Hand Hygiene Competency" dated "12.2019" showed "...When to wash hands...Before each resident contact...After touching a resident or handling their belongings...After handling contaminated items (linens/garbage/briefs, etc.) ...When can hand sanitizer be used...Before/after direct contact with resident...After contact with resident's intact skin...After contact with inanimate objects, such as medical equipment in resident's room or vicinity..."	F 880	education. 3. Monitoring: o The Infection Preventionist or designee will observe at least 3 meal services weekly for 4 weeks to ensure compliance with hand hygiene and glove use. o After 4 weeks, random observations (minimum 2 per week) will continue for an additional 2 months. o Non-compliance will result in immediate re-education and disciplinary action as appropriate. 4. Quality Assurance: o Findings will be reported monthly to the QAPI committee for ongoing review and evaluation. o The committee will determine if further action is required based on compliance trends. _____ _____	